

NON EMERGENCY HEALTH CARE FOR ADULT INDIVIDUALS UNABLE TO CONSENT

This form is designed to conform to the requirements for obtaining surrogate consent for adults unable to consent to health care in accordance with Adult Healthcare Consent Act (hereinafter the "AHCCA"), S. C. Code Ann 44-66-10, et seq (Supp. 2000) and Departmental Directive, 535-07-PD. (USE BLACK INK AND WRITE LEGIBLY)

Name of Individual: _____

Date: _____

I. Proposed Health Care

II. Certification of Inability to Consent

The undersigned two licensed physicians certify that they have examined the individual and, based on their independent examinations, it is their professional opinion and judgment that: (Check all that apply).

- ☐ The individual is unable to appreciate the nature and implications of his/her conditions and the proposed health care.
- ☐ The individual is unable to make a reasoned decision concerning the proposed health care.
- ☐ The individual is unable to communicate a decision concerning the proposed health care in an unambiguous manner.

The basis for this medical opinion and conclusion is supported by the following facts and observations:

1) The Cause of the individual's inability to consent is: _____

2) The Nature of the individual's inability to consent is: _____

3) The Extent of the individual's inability to consent includes, but is not limited solely to, the following health care issues:

- ☐ Medical/Diagnostic Care, Studies, and Procedures
- ☐ Psychotropic Medications
- ☐ Restrictive or Intrusive Programming/Behavior Support Plans
- ☐ Admission/Placement/Discharge to or from an DDSN associated entity/program

Explanation of Exceptions: _____

4) The Probable Duration of the individual's inability to consent is: _____

- 5) A Delay In Application of the proposed health care beyond the above stated time presents a substantial risk of death, impairment of functioning of a bodily organ, or other serious threat to the health and safety of the patient. Yes ___ No ___

We, the undersigned, hereby state that we are licensed physicians and have personally examined the above named individual and, based on our observations and conclusions as stated above, believe that the individual is unable to consent to the proposed health care and is in need of a surrogate that can make health decisions in the best interest of this individual.

First Physician: _____
Date of Exam: _____

Second Physician: _____
Date of Exam: _____

Additional Observations/Impressions: _____

III. Surrogate Selection

- 1) Court Appointed Guardian: _____
(Attach court papers)
- 2) Durable Power of Attorney: _____
(Attach legal papers)
- 3) Other Statutory Provision: _____
(Attach documents verifying authority)
- 4) Spouse: _____
- 5) Parent or Adult Child: _____
- 6) Adult sibling, Grandchild, or Grandparent: _____
- 7) Relative by blood or marriage who reasonably is believed to have a close personal relationship with individual unable to consent:: _____
- 8) Person given authority by other statutory provision: _____

Surrogate Information

Full Name: _____
Address: _____
Phone Number: _____

REVIEW OF INABILITY TO GIVE INFORMED CONSENT (at least annually during IPP)

Date of Review

Print Name and Sign

The completed original of this form will be placed in the individual's medical chart